Commission to Study Mental and Behavioral Health

In Maryland

2022 Annual Report

Lieutenant Governor Boyd K. Rutherford, Chair

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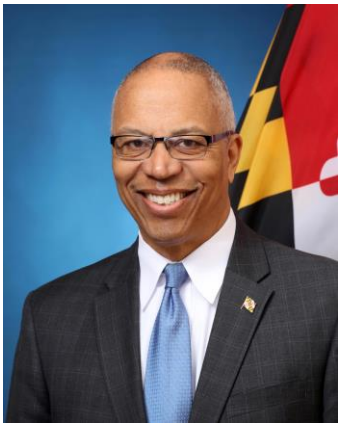
Letter from Lt. Governor Rutherford to Governor Hogan



Dear Governor Hogan,

Since the establishment of the Commission to Study Mental and Behavioral Health in Maryland in 2019, we have made great strides in improving the state's mental and behavioral health delivery systems. We've continued to advocate for treatment and access to resources for those Marylanders and their families in need.

Our work's impact can be seen through the state's Fiscal Year 2024 (FY24) budget preliminary recommendation to provide $100 million to Sheppard Pratt to expand behavioral health services in Maryland. We are proud that our work has helped guide the state in a direction that will help transform and expand Maryland's health system.

Enclosed is our 2022 report: the final report from the Hogan-Rutherford administration. This report outlines the work of the commission for the last year and includes final recommendations from each subcommittee. Those recommendations include continuing to promote standardized training in behavioral health, addressing workforce shortages in the correctional system for mental and behavioral services, and expanding the intensive home, community based, and youth services throughout the state.

In 2022, the Commission held six meetings, including two in-person meetings in September and November. The meetings included presentations on the impact of the COVID-19 pandemic on mental and behavioral health and the proposed Danger Standard Regulations; and updates from the Maryland Department of Health, the Behavioral Health Administration's Crisis System & Dangerousness Standard, The Lower Shore Clinic Assertive Community Treatment Program, and the Maryland Center for School Safety.

The Commission has recommended to the next administration to continue to focus on the issues of mental health and the co-occurring issue of substance misuse. I believe that our work throughout these last three years has greatly impacted our state for the better, and the Commission's work should continue in whatever form the new administration chooses. Thank you Governor Hogan for taking action in helping Marylanders in need, and for your continued support of the Commission.

Sincerely,

Boyd K. Rutherford
Lieutenant Governor of Maryland
Chair, Commission to Study Mental & Behavioral Health in Maryland

Background

Over the past eight years, the Hogan-Rutherford Administration prioritized efforts to address Maryland's significant, but previously overlooked heroin and opioid epidemic. Since January of 2015, the Administration has pursued a holistic, comprehensive response to this public health emergency through a multi-pronged approach encompassing education and prevention, treatment and recovery, and law enforcement efforts. Just one month into office, Governor Larry Hogan issued Executive Order 01.01.2015.12, creating the Maryland Heroin and Opioid Emergency Task Force. The governor tasked Lieutenant Governor Boyd Rutherford with leading the task force. Since then, the lieutenant governor has led and highlighted the administration's ongoing efforts to combat the epidemic.

The Administration has since taken numerous steps to invest critical funding; improve collaboration and communication among government agencies at the local, state, and federal levels; raise public awareness of the issue; and broke down the stigma surrounding the disease of addiction. Such efforts include, but are not limited, to the creation of the Opioid Operational Command Center and the Inter-Agency Heroin and Opioid Coordinating Council, authoring numerous pieces of legislation, and the issuance of an official State of Emergency.

It is through this work that Lt. Governor Rutherford recognizes the vital need for the state's approach to expand further and explore the mental and behavioral health needs of the citizens of Maryland, particularly those suffering from substance use disorder. Just as there is a stigma attached to substance use disorder, issues related to mental and behavioral health are equally stigmatized, if not more so. Additionally, it is widely accepted by advocates and medical professionals that there is a strong correlation between mental health and substance use disorders. To that end, it was decided that the state should further study the relationship between mental health and substance use disorders, as well as identify potential ways to improve our mental health services delivery system. On January 10, 2019, Governor Hogan issued Executive Order 01.01.2019.02, formally creating the Commission to Study Mental and Behavioral Health in Maryland (Commission).

Introduction

In 2022, the Commission conducted four virtual meetings and two in-person meetings to engage the public and the mental health community and gather feedback as it relates to mental and behavioral health, substance use, and the delivery of care. The Commission has learned that across the country, there has been a historically separated diagnosis and treatment of mental illness from physical illness. This has unintentionally caused two separate, and not always equal, systems of care. This not only affects the quality of treatment for individuals but raises the cost of care for all. It is more critical than ever to take a serious look at how the state provides care and services to individuals and their families. In addition to a higher likelihood of substance use disorder, individuals with undiagnosed mental health disorders are more likely to experience homelessness, joblessness, negative interactions with the judicial system, and become victims of crime and/or suicide.

Pursuant to the Executive Order, the Commission is required to submit recommendations to Governor Hogan for policy, regulations, and/or legislation to improve the continuum of mental health services, as well as, but not limited to, the following: (1) improving the statewide, comprehensive crisis response system and (2) ensuring parity of resources to meet mental health needs. We have heard testimony from persons suffering from disorders, family members and caregivers, educators, faith leaders, researchers, elected officials, law enforcement agencies, treatment professionals, advocates, and other stakeholders. This 2022 report reflects the Commission's work over the past year, the work of individual subcommittees, and updates on implementing previous years recommendations, as well as additional recommendations moving forward.

2022 Meetings:

● January 11	Virtual	Livestream
● March 8	Virtual	Livestream
● May 10	Virtual	Livestream
● July 12	Virtual	Livestream
● September 13	Hybrid	Livestream
● November 15	Hybrid	Livestream

Commission Members

Lieutenant Governor Boyd K. Rutherford, Chair
Senator Adelaide C. Eckardt, District 37, Caroline, Dorchester, Talbot, and Wicomico Counties
Senator Katie Fry Hester, District 9, Carroll and Howard Counties
Delegate Karen Lewis Young, District 3A, Frederick County
Richard Abbott, Representative of the Chief Judge of the Court of Appeals
Tricia Roddy, Deputy Medicaid Director, Maryland Department of Health (MDH)
Dr. Lisa A. Burgess, Deputy Secretary (Acting, Behavioral Health), MDH
Lieutenant Colonel Roland Butler, Maryland State Police
Dr. Lynda Bonieskie, Department of Public Safety and Correctional Services
Tiffany Rexrode, Acting Assistant Deputy Secretary, Department of Human Services
Kathleen Biranne, Commissioner, Maryland Insurance Administration (MIA)
Robin Rickard, Executive Director, Maryland Opioid Operational Command Center
Christian Miele, Deputy Secretary, Department of Disabilities
Mary Gable, Maryland State Department of Education
Barbara Allen, Public Member
Patricia Miedusiewski, Public Member
Dr. Bhaskara Rao Tripuraneni, Public Member
Cari Cho, Public Member
Serina Eckwood, Public Member
Kimberlee Watts, Public Member

Subcommittees

Based on the areas of concern raised during this Administration's tenure and feedback from stakeholders, the Commission created four subcommittees: (1) Youth & Families; (2) Crisis Services; (3) Finance & Funding; and (4) Public Safety/Judicial System. These four subcommittees are focused on the basic fundamental and policy issues facing each of these subject areas. Each subcommittee is chaired by one or two members of the Commission who solicit the participation of stakeholders interested in each subject area. The following section details the initial focus areas of each subcommittee and the progress thus far.

Youth and Families Subcommittee

Christian Miele Deputy Secretary, Maryland Department of Disabilities Christian Miele
Tiffany Rexrode, Acting Assistant Deputy Secretary, Department of Human Services

Overview

The Youth and Families Subcommittee was created because 1 in 6 youth ages 6-17 have or will have a serious mental illness (JAMA Pediatrics, 2019); suicide is the second leading cause of death among adolescents and young adults aged 10-34 (CDC, 2019); roughly half of all lifetime mental illnesses begin in mid-teens (Curr Opin, 2007); and increasing evidence shows that interventions during the early stages of a disorder may help to reduce the severity and/or persistence of the disorder and could prevent secondary disorders (Epidemiol, 2012). With an increase in school violence in recent years, addressing youth and adolescent behavioral health is more important than ever.

Focus Areas

K-12 education: The subcommittee continued to review current programs in the school systems that provide mental and behavioral health support and services to students and school-aged children. It was brought to the attention of the subcommittee that there are obstacles in Maryland to reimburse school counselors through Medicaid.

Caregivers and Families: There was public testimony surrounding the danger standard in the involuntary commitment statute. Youth and Families established a workgroup to look at the language and attempt to submit a recommendation to the full Commission. This group met three times, and information was submitted to workgroup members surrounding language used by other states as well as the Grading the States report by the Treatment Advocacy Center. Workgroup members were asked to review language used by other states and language used in HB1344 to find three examples of language they felt comfortable with or create their own language. Members could not come to an agreement on language. The group agreed that extensive training on the interpretation of the danger standard for all groups that utilize the standard is important. This topic will continue to be an issue for future policymakers.

Organizing Efforts

The Youth and Families subcommittee met six times virtually, with workgroups meeting more frequently throughout the 2022 calendar year. The meetings consisted of presentations on various topics including the need for Medicaid reimbursement for Maryland's school psychologist, Involuntary Commitment Statute, Assisted Outpatient Treatment, legislative updates, Behavioral Health Administration, Children, Adolescent and Young Adult Services updates, Greater Baltimore Regional Integrated Crisis System implementation, and an update on Montgomery County crisis services.

Participants

Barbara Allen, James Place Inc.; Dr. Bhaskara Tripuraneni, Child/Adolescent Psychiatrists-Kaiser Permanente Participants: Dr. Aliya Jones, Deputy Secretary Behavioral Health Administration; Teresa Heath, Maryland Emergency Management Administration; Bari Klein, Healthy Harford, Inc.; Dawn Luedtke, Maryland Center for School Safety; Regina Morales, Montgomery County Department Health and Human Services; Kirsten Robb-McGrath, Department of Disabilities; Ann Geddes, Maryland Coalition of Families; Dan Martin, Mental Health Association of Maryland; Lauren Grimes, Community Behavioral Health Association of Maryland; Toni Torsch, Daniel C. Torsch Foundation; Courtnay Oatts-Hatcher, School Psychologist; Christina Connolly, School Psychologist; Robert Anderson, Department of Juvenile Services; Dr. Beverly Sargent, Youth Service Bureau; Allyson Lawson, Psychiatric Nurse; Liz Park, Youth Service Bureau; Dr. Jackie Stone, Kennedy Krieger Institute; Christine Grace, School Psychologist; Nancy Lever, National Center for School Mental Health; Laura Mueller, WIN Family Services; Jenn Lynn, Upcounty Community Resources; Rowan Powell, On Our Own of Maryland; Ann Ceikot, Policy Partners; Evelyn Burton, Maryland Chapter Schizophrenia and Related Disorders Alliance of America; Caren Howard, Mental Health America; Kate Farinholt, NAMI; Kevin Keegan Catholic Charities; Robin Murphy Disability Rights Maryland; Katie Rouse, On Our Own Maryland; Brian Stettin, Treatment Advocacy Center; Jennifer Redding University of Maryland Upper Chesapeake Health; Dr. Erik Roskes, Community Forensic Psychiatrist; Erin Dorrien Maryland Hospital Association; Katie Dilley, Mid-shore Behavioral Health; Tammy Loewe, St. Mary's County Local Behavioral Health Authority; Steve Johnson, Behavioral Health Systems Baltimore; Kate Wyer, Mental Health Association Maryland; Erin Knight, Consumer Quality Team; Brande Ward, Maryalnd Peer Advisory Council & Cherokee Nation Estern Band; Julvette Price, Behavioral Health Systems Baltimore; Phyllis McCann, Behavioral Health Administration; Morgan Clipp, Office of the Attorney General; Eleanor Dayhoff, Office of the Attorney General; Carroll McCabe, Office of the Public Defender; Dr. Scott Moran, BHA; Dr. Steven Whitefield, BHA; Marian Bland, BHA (chair); Sharon Lipford, BHA.

Crisis Services Subcommittee
Dr. Lisa A. Burgess, Deputy Secretary, Behavioral Health Administration (Effective May, 2022)
Dr. Aliya Jones, Deputy Secretary, Behavioral Health Administration (January – May, 2022)
Steve Schuh, Deputy Secretary Health Care Financing and Medicaid
Robin Rickard, Executive Director, Opioid Operational Command Center

Overview
The mission of the Mental and Behavioral Health Commission's Crisis Services Subcommittee (CSS) is to identify gaps in Maryland's crisis response system and to make recommendations on addressing these gaps. In December 2019, the CSS submitted its first recommendations to the Lt. Governor, the first of which was for Maryland to develop a comprehensive crisis response system where there would be minimum service standards statewide. The Maryland Department of Health's Behavioral Health Administration (BHA) is the most appropriate state agency to advance this work, and has created the Maryland Crisis Services Workgroup (MCSW) to help Maryland establish a comprehensive crisis response system. Five workgroups were established as part of the MCSW: Best Practices/Standardization; Children/Adolescent and Young Adult; Data Dashboard and System Mapping; Financial Stability and Sustainability; and 988 Integration.

Focus Areas
The Maryland Crisis System vision: To develop a comprehensive, public/private, integrated behavioral health crisis care system. Maryland residents of all ages will have 24/7 access to hotline, mobile crisis response teams and walk-in/crisis stabilization center services that provide the most effective, least restrictive, person and family-focused behavioral health care. The framework for the crisis system is based on Substance Abuse and Mental Health Services Administration (SAMHSA) best practice guidelines and includes Someone to Call (Call Center/988), Someone to Respond (Mobile Crisis Response Teams) and Somewhere to Go (Walk-in/Crisis Stabilization Centers and Residential Crisis Beds).

Organizing Efforts
The Maryland Crisis System Workgroup (MCSW) is composed of 125 diverse stakeholders from around Maryland including representatives from state and local government, providers, advocates, and people with lived experience. The MCSW met six times between February and December 2022.

Included in this workgroup were discussions about determining the state's service capacity for individuals with both substance use and mental disorders. This topic will likely continue to be explored and additional work built on the efforts by Baltimore City and County.

Participants

Adrienne Mickler, Alexis Capestany, Allen Twigg, Dr. Aliya Jones, Ameejill Whitlock, Andrea Brown, Andrew Guy, Angela Onime, Ann Ciekot, Ann Geddes, Ashley Johnson, Barry Page, Billina Shaw, Brendan Welsh, Carlos Mackall, Carmen Lopez-Arvizu, Catherine Gray, Connie Martin, Christine Milano, Crista Taylor, Dan Martin, Daniel Kornfield, Daniel Rabbitt, Darren McGregor, Daryl Plevy, Deana Krizan, Debbie Hawkins Del. Karen Lewis Young, Dionne Bowie, Dorne Hill, Dr. Lisa A. Burgess, Erin Schurmann, Ed Soffe, Elizabeth Kasameyer, Dr. Eric Weintraub, Erin Dorrien, Fred Chanteau, Gina Eckart, Dr. Harsh K. Trivedi, Heather Shek, Heidi Bunes, Holly Wilcox, Howard Ashkin, Iva Jean Smith Jacqueline E. Somerville, James Rhoden, James Yoe, Jeff O'Neal, Jennifer Corbin, Jennifer Lowther, Jennifer Redding, Jessica Kraus, Jessica Sexauer, Joe Petrizzo, Kandy McFarland, Kate Farinholt, Kathleen Rebbert-Franklin, Kathryn Dilley, Katie Rouse, Kaylin McJilton, Kelsey Hulteng, Kevin Keegan, Laura Burns-Heffner, Lisa Fassett, Lori Doyle, Lori Bradford, Mara Weinstein, Margaret Fowler, Dr. Maria Rodowski-Stanco, Marian Bland, Mariana Izraelson, Marianne Gibson, Marion Katsereles, Marshall Henson, Mary Kay Tierney Mary Viggiani, Maryana Townsend, Megan Peters, Michael Clark, Michael Udwin, Michelle Zabel, Mindy Kim-Woo, Moira Cyphyers, Nancy Rosen-Cohen, Oleg Tarkovsky, Patricia Miedusiewski, Quinton Askew, Rebecca Raggio, Rhonda Callum, Robin Rickard, Rodney Kornrumpf, Samantha Moorhead, Sarah Myers, Scott Graham, Scott Rose, Senator Katie Fry Hester, Serina Eckwood, Sharon Lipford, Shelly Gulledge, Stacey Walker, Stacy DelVecchio, Stephanie House, Stephanie Knight, Stephanie Slowly, Steve Schuh, Steve Thomas, Dr. Steven Whitefield, Susan Bradley, Tammy M. Loewe, Tatiana Reyes, Thomas Merrick, Tiffany Russell, Timothy Feist, Tricia Roddy, Uma Ahluwalia, Vamsi Kalari, Vickie Walters, Victor Welzant, Will Andalora.

Finance and Funding Subcommittee
Kathleen Birrane, Commissioner, Maryland Insurance Administration (MIA)
Tricia Roddy, Deputy Medicaid Director, Maryland Department of Health (MDH)

Overview
The Finance and Funding Subcommittee is tasked with assessing how finance and funding in the public and private health insurance markets affect access to behavioral health services. The focus areas of the subcommittee run parallel with the efforts of MDH's System of Care Integration and Optimization Workgroup and are well aligned with the MIA's regulatory enforcement measures to address network adequacy and mental health parity issues in the private sector. Given the substantial role of both the public behavioral health system and the commercial insurance market in delivering and financing behavioral health services in Maryland, the subcommittee focus areas will make an important contribution to the Commission's work.

Focus Areas
Public Mental and Behavioral Health: Subcommittee discussions focused on furthering the work on the System of Care Integration and Optimization Workgroup, and on additional work to support the coordinated efforts to further improve Maryland's crisis services for both youth and adults. This work was directly reflected in many of the initiatives discussed in this report, such as the Governor's FY2024 budget recommendations, and in the $140 million in new Medicaid crisis services that are being implemented between now and July 1, 2023.

Medicaid Focus Area

- The Maryland Department of Health's Medical Assistance Program continues to implement over $140 million in new crisis services programs that were submitted as part of the Governor's budget and approved by the General Assembly between now and July 1, 2023.

- *Crisis Care Continuum: Mobile Crisis Services and Crisis Stabilization Units*
    - The crisis care continuum is critical for those experiencing a behavioral health crisis. MDH is developing a statewide mobile crisis response and crisis stabilization system in an effort to build out the crisis care continuum. These two services will be available to both Medicaid individuals and those who lack insurance coverage.

    - Mobile crisis units operate on a 24/7 basis. Two-person teams will respond to crises on-scene and attempt to stabilize the individual. Maryland Medicaid will begin reimbursing for mobile crisis services in July 2023 (FY 24).

    - Crisis stabilization units (CSUs) provide up to 23-hour care for people experiencing behavioral health crises in lieu of an emergency room or hospital. Maryland Medicaid will reimburse CSUs beginning July 2023 (FY 24).

- *Maternal Opioid Misuse Model*

    - The Maternal Opioid Misuse (MOM) Model addresses fragmentation in the care of pregnant and postpartum Medicaid beneficiaries with opioid use disorder (OUD) through a statewide approach involving collaborative work with its nine managed care organizations (MCOs), improved data infrastructure, and strengthened provider capacity in underserved areas of the state.

    - MOM model efforts focus on increasing utilization of ambulatory and behavioral health care, such as medication for OUD, through enhanced MCO case management; improving provider capacity, especially in rural areas, to treat pregnant and postpartum participants with OUD; and ensuring families have access to the community resources that they need by leveraging enhanced care coordination and health information technology infrastructure.

- MOM model services started on July 1, 2021 as a one year pilot in St. Mary's County. Beginning FY 2023, after the culmination of the pilot, the model expanded into the following counties: Anne Arundel, Baltimore, Baltimore City, Cecil, Garrett and Harford. Effective January 1, 2023, the MOM model will expand to be completely statewide, with services available to all eligible HealthChoice members.

- *Certified Peer Recovery Supports for SUD*

  - MDH is leveraging funding through the American Rescue Plan Act (ARPA) 10% eFMAP to implement coverage for certified peer recovery specialists (CPRS) for substance use disorders (SUD) through Medicaid. A CPRS uses lived experience in recovery to help others. A CPRS may facilitate support groups or work one-on-one with individuals seeking or maintaining recovery. Medicaid will reimburse for services beginning March 2023.

Maryland Insurance Administration Focus Area

- The Maryland Insurance Administration (MIA) recommends finalizing proposed changes to the existing network adequacy regulations that will strengthen the standards specific to mental health and substance use disorder services and ensure all carriers use consistent methodologies to measure and report compliance. These changes will enhance the MIA's ability to identify the areas where carrier provider networks are deficient and analyze the underlying causes, allowing the MIA to more effectively leverage its enforcement of the network adequacy regulations to achieve meaningful results.

Organizing Efforts

The Finance and Funding Subcommittee held six meetings in 2022 to receive input on focus areas from its members and participants. In addition to the work of the Finance and Funding subcommittee, MDH has been working concurrently on its Behavioral Health System of Care Integration and Optimization Workgroup and coordinating with the Subcommittee. The MIA's Network Adequacy and Mental Health Parity Workgroups have worked diligently with internal and external stakeholders throughout the year. Their efforts have also been coordinated with the Subcommittee.

Participants

Senator Adelaide Eckardt, District 37; Patricia Miedusiewski, Family Advocate; Cari Cho, Cornerstone Montgomery; Nick Albaugh, Director of Licensing & Compliance, Amatus Health; Dr. Robert Ciaverelli, Medical Director for Behavioral Health, CareFirst; Isaiah Coles, Chief Operating Officer, Outreach Recovery; David Stup, Director of Corporate Business Development, Delphi Behavioral Health Group; Mark Luckner, Executive Director, Maryland Community Health Resources Commission; Patryce Toye, Chief Medical Officer, MedStar Health Plans; Dr. Jill RachBeisel, Interim Chair of Psychiatry, University of Maryland School of Medicine.

Public Safety/ Judicial System Subcommittee
Senator Katie Fry Hester, District 9
Dr. Lynda Bonieskie, Deputy Secretary, Department Public Safety and Correctional Services

Focus Areas
This year the Public Safety/Judicial System subcommittee focused on implementation of the Behavioral Health and Public Safety Center of Excellence. This included two subcommittee meetings and the 2nd annual Sequential Intercept Model (SIM) Summit, hosted by the Governor's Office of Crime Prevention, Youth, and Victim Services on November 14th and 15th, 2022.

In February the subcommittee was briefed by Lt. Steve Thomas and Jen Corbin on how the Anne Arundel County Police Department has been integrated into the mental health system through Crisis Intervention Teams (CIT), mental health training for officers, and the Safe Station Program. The goal of the program is to prevent crises before they escalate and divert to hospitalization rather than the correctional system – and has become so successful within the community, calling the warm line instead of 911 and asking for a CIT team to be sent out. The program includes the following components:

- All police officers in Anne Arundel County receive mental health aid training, with 25% of inclined officers receiving additional mental health crisis training.
- The CIT pairs licensed clinicians and police officers together on a mobile team to respond to mental health calls.
- The Safe Station Program allows any person in need of treatment to enter police station for referral to health services.
- Frequent communication with judges avoids unnecessary incarceration for individuals in need of treatment.

In August, the subcommittee discussed the "Upstream" model, a SIM process used in Massachusetts and Indiana for children and families. Teri Deal from the National Center of State Courts presented on Upstream. Upstream is used in the judicial system to enhance community collaboration and improve outcomes. By connecting courts with the community and families with risk factors, the court can reduce the number of families with allegations and families with court involvement and implement best practices for involved families. The Upstream model has been beneficial to Massachusetts and Indiana as it has improved outcomes for children and families, strengthened court capacity, and found community-driven solutions for community-specific needs.

In November of 2022, the Center of Excellence hosted the second annual Summit on Behavioral Health and the Justice System: Utilizing the Sequential Intercept Model. The Summit was a continuation of the work started by the subcommittee in 2020 to formalize sequential intercept mapping in Maryland. The 2 day in-person summit included stakeholders from across the state to listen to presentations on best practices along the Sequential Intercept Model and

hold workgroups to identify gaps and opportunities along each intercept. Participants included public defenders, state attorney's, social workers, psychologists, law enforcement, non-profit organizations, local and state government, and members of the Public Safety and Judicial System subcommittee. The materials from SIM Summit and the strategic plan should be available on the Commission to Study Mental and Behavioral Health in Maryland in the near future.

Over the course of the year, the subcommittee received updates from the Behavioral Health Center of Excellence on their progress. Since its inception, the Center of Excellence has:

- Hired two staff members
- Held the first Train-the-trainers program, consisting of 25 graduates from across the state
- Partnered with the University of Maryland to develop a multi-year strategic plan. The team at University of Maryland have conducted interviews with key stakeholders across the state to evaluate the deficiencies in services.

Further questions about the Center of Excellence can be addressed to Jim Rhoden, Assistant Director, Center of Excellence.

Organizing Efforts

The Public Safety/Judicial System subcommittee met two times this year. The focus of the subcommittee was on implementation of the Behavioral Health and Public Safety Center of Excellence, and further exploration of best practices under the Sequential Intercept Model (SIM).

Participants

Senator Katie Fry Hester, Dr. Lynda Bonieskie, Richard Abbott, Lt. Colonel Roland Butler, and Kimberlee Watts, Tammy Holt, Governor's Office of Crime Prevention, Youth, & Victim Services; Dr.Debra Pinals, Forensic Director of Michigan; Mara Weinstein, Pew Charitable Trust; Tiffany Russell, Project Director at Pew Charitable Trust; Lt. Steve Thomas, Anne Arundel County Crisis; Jen Corbin, Anne Arundel County Crisis, Taiana Reyes, Governor's Office of Crime Prevention, Youth, & Victim Services; Teri Deal, National Center for State Courts; Nora Sydow, National Center for State Courts; Michelle O'Brien, National Center for State Courts

Progress Update: 2021 Recommendations

Recommendation One: Design a Comprehensive Crisis System

Significant progress has been made in partnership with the Maryland Medicaid Administration and behavioral health stakeholders to develop and implement the Maryland Crisis System, including the state's implementation of 9-8-8 and 2-1-1, press 4. The Maryland Crisis System Model is working to help ensure that individuals experiencing a behavioral health crisis can access the most appropriate services in the most appropriate settings.

2022 Update: Governor Hogan made preliminary recommendations for the state's Fiscal Year 2024 (FY24) budget, including expanding access to health care for vulnerable communities. Many of these recommendations were informed by the recommendations from the Commission, including **$100 million** to Sheppard Pratt to expand behavioral health services in Maryland, including expanded capacity at its new Elkridge campus, a new dedicated children's hospital in Towson, a neuroimaging center to advance cutting-edge research, and a global training center for workforce development.

As Maryland develops and implement the Maryland Behavioral Health Crisis System, goals for the future include:

- Supporting the creation of regional crisis stabilization centers across Maryland;
- Supporting behavioral health providers in the implementation of COMAR 10.63 crisis regulations;
- Implementing HG §10-621 - Crisis Stabilization Centers to accept emergency petitioned individuals and divert them from hospital emergency departments;
- Supporting and expanding the implementation of the Care Traffic Control Platform across Maryland; and
- Pursuing the development of all-payer reimbursement for crisis services.

Recommendation Two: Continue Coordination with the System of Care Optimization and Integration Workgroup

The Behavioral Health System of Care Workgroup has been rebranded as the System of Care Optimization and Integration Workgroup and has resumed meeting again in 2021. The group discusses various behavioral health focused initiatives, including data sharing.

Despite delays due to COVID-19, the System of Care Optimization and Integration Workgroup is working on various technical implementation issues. The State is evaluating how it should provide, administer, and finance behavioral health in conjunction with the Total Cost of Care Model that increases the coordination and quality of somatic and behavioral health care for Medicaid enrollees. This new model will be cost efficient and promote access to care. A well-functioning behavioral health system should include five key components: (1) Quality Integrated Care Management; (2) Oversight and Accountability; (3) Cost Management; (4) Access to Behavioral Health Services through Provider Administration and Network Adequacy; and (5) Parity. The Commission will continue to work with the relevant stakeholders and the System of Care Optimization and Integration Workgroup to identify specific system improvement.

Workgroup discussions are picked back up and continued into 2021. Although Workgroup meetings were placed on hold, progress was made in the following areas:

● One of the draft improvement categories of the System of Care Workgroup was improving access to crisis services. MDH was recently awarded a grant from the OOCC to provide assistance to select outpatient mental health center providers to become comprehensive crisis stabilization centers. This will be a multi-year initiative, and activities are underway.

● Adult access to psychiatric treatment services within institutions of mental diseases (IMDs) was another area of discussion within the System of Care Workgroup. The Centers for Medicare & Medicaid Services has historically prohibited Medicaid coverage of these services. The Department submitted an exclusion waiver application in 2015 to Centers for Medicare & Medicaid Services for both substance use disorder and psychiatric providers. Centers for Medicare & Medicaid Services denied the psychiatric IMD exclusion waiver request but approved the substance use disorder residential request. With Centers for Medicare & Medicaid Services approval, the Department expanded this waiver in 2018 to cover adults with a primary diagnosis of substance use disorder and a secondary diagnosis of a mental health condition in a psychiatric IMD. Centers for Medicare & Medicaid Services has recently changed policy 17 regarding psychiatric IMD waivers. MDH submitted another psychiatric IMD waiver request as part of the waiver renewal process during the summer of 2021. Centers for Medicare & Medicaid Services approved the waiver application on December 14, 2021.

● In response to System of Care Workgroup discussions, the Department is working on developing behavioral health provider and local systems management manuals.

● Upcoming discussions will include data sharing, among other topics.

Recommendation Three: Increase funding for Second Chance Act Grant

Current federal funding for Second Chance Act grants stands at $90 million distributed across all states. Lt. Governor Rutherford sent a letter to the leadership of the United States House and Senate Appropriations committees requesting $100 million in Second Chance Act funding. Maryland Senators Ben Cardin and Chris Van Hollen, as well as Congressman David Trone sent responses indicating the House and Senate Appropriations bills included a $10 million increase for Second Chance Act Funding. The Lt. Governor's letter and congressional responses appended to this report (See Appendix A) In the fiscal year 2021 omnibus bill, Congress funded the Second Chance Act program at $100 million, representing a $10 million increase from fiscal year 2020. The fiscal year 2022 House Appropriations bill for Commerce, Justice, and Science contains $125 million for Second Chance Act grants, which would be a $25 million increase over fiscal year 2021.

Recommendation Four: Improving the Crisis Hotline

The Maryland Department of Health, Behavioral Health Administration (BHA) has worked over the last year to transition our primary statewide crisis hotline from 211 Press 1 to the new nationally recognized number 988. While 211 Press 1 is still fully operational and continues to answer calls/texts/chats, we are no longer actively promoting this number. Currently, we are using 988 (formerly the National Suicide Prevention Lifeline) as the primary "someone to call" component of our Maryland Crisis Model.

Significant efforts are being made to fully integrate 988 into our crisis system. This included efforts to incorporate 988 into the dispatch of mobile crisis units to those in need. It also included activities related to diverting appropriate 911 calls that are behavioral health related to 988. BHA has applied for and was awarded a SAMHSA 988 State and Territory Grant that is helping to provide additional funds to add capacity.

While the initiative described above tends toward responding to a behavioral health crisis, we have also been involved in using crisis hotline resources for more proactive and preventative programming. The Maryland Health Check (MD Health Check) is a program started as a result of HB 669. The program is currently funded with federal supplemental block grant funds and continues to see significantly increasing demand. The program provides behavioral health check-in calls to participants in order to assist in addressing the person's behavioral health needs.

2022 Update: In July of 2022, the Maryland Department of Health launched two resources for the public to support those with mental health and substance use disorders. 211, press 4 was launched as a resource for individuals who stay in emergency departments for a long time while waiting for treatment placements with either inpatient or outpatient providers. 211, press 4 connects hospital discharge planners or individuals with care coordination services to accomplish appropriate and quick placements. In partnership with SAMHSA, the Maryland Department of Health launched a state-wide suicide hotline, 988 to help those in crisis.

Recommendation Five: Promote Standardized Training in Behavioral Health

BHA has worked with and through numerous providers to conduct educational/training meetings culminating in 35 instructor-led virtual and/or in-person training sessions attended by over 4,800 provider staff, and monthly provider council meetings. The goal is to discuss and promote standardized training in behavioral health. Trainings have included: Maryland's 33rd Annual Suicide Prevention Conference; Extreme Risk Protection Orders: A Health Interventions for Preventing Firearms Suicide; Implementing and Sustaining an Integrated Crisis System in the Baltimore Region; Assessing for Suicide Risk in Kids, etc.

In April 2022, the Behavioral Health Administration (BHA) expanded funding to the Mental Health Association of Maryland for Mental Health First Aid trainings for Maryland's four Historically Black Colleges and Universities (HBCUs): Morgan State University, Bowie State University, Coppin State University, and University of Maryland, Eastern Shore. This initiative aims to train up to 20,000 students, faculty, and staff across the four HBCUs. In Maryland, 52 percent of Black high school students (ages 14 to 19) reported feeling significantly sadder and more hopeless the past year compared to the statewide average of 36 percent, according to the 2021 Youth Pandemic Behavior Survey. In 2019, suicide was the third leading cause of death for Black Americans ages 15 to 24, according to the Centers for Disease Control and Prevention. Mental Health First Aid Training provides the opportunity for students, faculty, and staff to learn when they, or someone they know, may benefit from mental health and substance abuse treatment. The training also teaches people how to engage in conversations around this need including how to address social stigma and connect those in need with available resources.

Recommendation Six: Ensure proper warnings regarding cannabis use.

Draft cannabis edibles regulations (COMAR 10.62.01-.37) published in the Maryland Register on October 23, 2020 with a comment period ending on November 23, 2020. These regulations include labeling/warnings (see example here and Appendix B).

2022 Update: These regulations went into effect in 2021. Please see 2023 recommendations.

Recommendation Seven: Standardize Mental and Behavioral Health Programming in Schools

Maryland State Department of Education (MSDE), and local school systems use a Multi-Tiered System of Social-Emotional Support. There are three tiers, with Tier I providing instruction and services for all students; Tier II providing a higher level of services needed for small groups of students; while Tier III is designated for students with more individualized services. MSDE provided training on restorative practices in partnership with the University of Maryland School of Law; Positive Behavioral Interventions and Supports (PBIS); and trauma-informed approaches. Some trauma-informed approaches are: Youth Mental Health First Aid, Adverse Childhood Experiences (ACEs), School Counseling Interventions, and Mental Health and Well-Being. The Mental Health First Aid training is a "trainer of trainers" model which results in outreach and assistance offered to thousands of students across the State. All Local School Systems have planned systematic classroom-based Social and Emotional Learning (SEL), Restorative Approaches, PBIS, and additional programs. Several school systems also have Second Step (Elementary and Middle), Social and Emotional Foundation for Early Learning (SEFEL - targeting early education), Conscious Discipline, and several additional SEL programs. SEL is embedded in the Health, Physical Education, and Fine Arts curricula.

Recommendation Eight: Improve Access to Information and Services

● BHA promoted the 211 hotline https://pressone.211md.org/
● Promoted FDA's Remove the Risk toolkit that provides information on how to properly dispose of medications.
● Webinar on How to Administer Naloxone, where to obtain it and how to upload Naloxone Electronic Toolkit for Maryland business community
● BHA created two interactive service locator maps—Crisis Treatment Locator and Telebehavioral Health Provider Locator Map—to assist individuals in locating and accessing information about certain behavioral health services.
● BHA partnered with the Maryland Institute for Emergency Medical Services Systems (MIEMSS) on the Crisis Counseling for Essential Worker Partnership.

2022 Update: Please see 2022 update for recommendation four. Moving forward in addition to these, we should develop and implement a public awareness and training campaign to increase awareness and encourage the use of behavioral health advance directives, including both mental health and substance use.

Recommendation Nine: Clear Statutory Definition of Harm to Self and Others

Through the work of the Youth and Families subcommittee as well as compelling public testimony before the commission from family members of individuals in crisis, it is clear the State must develop a clear and unambiguous standard for determining when individuals in crisis pose a danger to themselves and others in order to give caregivers and public safety officials clear standards for action to alleviate this danger. The commission recommends legislation that provides a clearer statutory definition of danger of harm to self or others. The currently widely used standard of "immediacy" is insufficient. In February 2021, the Behavioral Health Administration (BHA) was charged by the Commission to Study Mental and Behavioral Health with reviewing current civil commitment laws and examining the definition of dangerousness and grave disability. From March 3, 2021 to April 20, 2021, BHA led a diverse group of stakeholders, hosting four workgroup meetings, to review national best practices on civil commitment and develop recommendations to provide greater clarity to Maryland's civil commitment definition. Through a collaborative process with stakeholders BHA has developed a proposal to update regulations defining harm to self and others and included data collection and training requirements.
2022 Update: Please see 2023 recommendations.

Recommendation Ten: Enact More Permanent Telehealth Reform.

Continued expansion of the use of telehealth to reduce barriers to service delivery, especially in communities without information technology resources and regions that lack suitable broadband infrastructure, is crucial. In particular expansion of telehealth to memorialize the authorization of audio only telehealth services. Maryland should permit mental healthcare practitioners licensed in any of the other states and the District of Columbia to provide telehealth services across state lines, providing they follow state laws and regulations pertaining to mental health professionals. Idaho has introduced model legislation to authorize such a regime.

In 2021 the General Assembly approved, and Governor Hogan signed into law HB 123/SB0003 The Preserve Telehealth Act. This law preserved the access to telehealth provided by Governor Hogan's emergency executive orders enacted to address access to mental and behavioral health services during the pandemic. The law preserves telehealth options through fiscal year 2023, pending a study by the Maryland Health Care Commission. To maintain the increased access to vital support and treatment, the Commission urges the General Assembly to make provisions of the Preserve Telehealth Act permanent and enact licensure reform to allow out-of-state mental and behavioral health practitioners to provide services to Marylanders.

2022 Update: The Maryland Department of Health promulgated regulations to align with this law.

Recommendation Eleven: Explore Assisted Outpatient Treatment (AOT) Pilot for Returning Citizens.

Maryland Department of Public Safety and Correctional Services (DPSCS), has a significant portion of its inmate population suffering from severe mental health disorders. Releasing these individuals into society with no plan of care will most likely result in reincarceration. A pilot outpatient civil commitment program operated by BHA offers a useful model for DPSCS.

Utilizing a grant from SAMHSA the BHA established an outpatient civil commitment pilot program in Baltimore City through Behavioral Health Systems Baltimore, for release of individuals involuntarily admitted for inpatient treatment under Health-General Article, Md. Code Ann. § 10–632.

Between 2018 and 2019 the program served seven individuals who received mental health services during their six-month involuntary commitment. The pilot program utilized a person-centered approach to care, where each individual in the program developed a treatment plan tailored to meet their unique health care needs and goals. To support the participant's program plan, goals, and ensure adherence to the program, peer recovery specialists met with each individual several times a week consistent, assertive, and trauma-informed outreach; case management; supportive counseling, and linkage to community resources. All mental health services received 23 by program participants were individualized and appropriate to the level of care required for that individual.

In June 2018 Behavioral Health Systems Baltimore relinquished the SAMHSA grant and BHA began funding the pilot program. Staff and stakeholders have learned many valuable lessons about the design and implementation of the outpatient civil commitment program in Baltimore City and the limitations of the SAMHSA grant. Specifically, staff and stakeholders learned that limiting enrollment to only those who have involuntary hospitalizations resulted in too few referrals. Regulatory changes implemented in September 2019 were designed to increase program participation. Additional regulations are being proposed to expand the service area.

The Department of Public Safety and Correctional Services should explore piloting a program similar to the outpatient civil commitment program for returning citizens who suffer from mental illness as deemed appropriate.

Recommendation Twelve: Expansion of Forensic Assertive Community Treatment (FACT) Teams

DPSCS should design an AOT pilot program for the population of inmates up for parole and probation to reduce the potential for re-engagement with the criminal justice system and reincarceration. Identify an empirically-supported fidelity tool to assess the effective implementation of FACT teams, as well as assessing the need for FACT teams statewide and expanding the use of FACT teams in defined geographic areas.

Prior to merging with the MCSW, the Crisis Services Sub-committee learned about the utility of FACT teams. The group received presentations on how they operate and associated outcomes. Moving forward, the Best Practices workgroup as part of the MCSW will consider the utility of expanding FACT teams.

Recommendation Thirteen: Extended Services for ACT Teams and Expand Geographical Areas of Need

Explore the types of expanded services Assertive Community Treatment (ACT) teams can take on and determine what type of incentives should be provided. Expand geographic areas in need of ACT teams defined by an empirically-based formula for estimating needed ACT capacity and a population size sufficient to sustain a fully-functioning ACT team. Expansion of ACT teams will occur as part of the Best Practices Workgroup under the Maryland Crisis Systems Workgroup.

Recommendation Fourteen: Obtain IMD Exclusion Waiver

Proceed with a psychiatric institute for mental disease (IMD) exclusion waiver request as part of the Department's substance use disorder IMD exclusion waiver renewal application. On July 13, 2021, Governor Hogan submitted a letter (see Appendix C) to the U.S Department of Health and Human Services seeking a Demonstration Waiver Renewal for HealthChoice, Maryland's Medicaid Managed Care program. The renewal application included a provision to cover adults in a psychiatric institution for mental disease (IMD) (or better known as a psychiatric IMD exclusion provision). CMS approved the waiver application on December 14, 2021.

Recommendation Fifteen: Explore Provider Reimbursement Rates as Non-Quantitative Treatment Limitations

Conduct further study of provider reimbursement rates as non-quantitative Treatment Limitations to evaluate whether rates are determined in a comparable manner for medical providers and behavioral health providers. Work with stakeholders to develop standards for the carrier non-quantitative treatment limitations reporting requirements that will ensure meaningful information is collected in an efficient manner that minimizes the administrative costs and burdens associated with the reports. Engage employer groups in the commercial self-funded market to determine what steps they have taken to increase access to behavioral health services and to identify strategies to collaborate on increasing access in the self-funded market.

Senate Bill 334, Chapter 619, Acts of 2020, requires commercial carriers to submit reports to the Maryland Insurance Administration (MIA) by March 1, 2022, which are intended to demonstrate compliance with the federal Mental Health Parity and Addiction Equity Act (MHPAEA). The state law also requires the MIA to adopt regulations and template reporting forms by December 31, 2021 to ensure uniform definitions and methodology for the required reports. The reports focus on the comparability of non-quantitative treatment limitations that are applied to mental health and substance use disorder benefits and medical/surgical benefits.

Throughout 2021, the MIA held three public hearings on this issue, researched and considered the approaches taken by other state and federal regulators, and engaged with various stakeholders, including consumer advocates, insurance carriers, and employers in the self-funded market. The MIA posted multiple draft versions of the proposed regulations and associated template forms and instructions to the MIA website for public comment during the summer and fall. The regulations (COMAR 31.10.51) were formally proposed in the Maryland Register on October 22, 2021 with a comment period ending on November 22, 2021. The regulations and associated templates will be finalized by the end of 2021.

To gain greater insight into possible disparities in reimbursement rates between behavioral health providers and medical/surgical providers, provider reimbursement was specifically added to the template reporting forms as a separate non-quantitative treatment limitations category that must be reported in addition to the other thirteen categories included on the original reporting form. The MIA also intends to require submission of a separate data supplement form that will collect uniform information on the comparability of reimbursement rates for specific services performed by medical/surgical providers and behavioral health providers.

As part of its efforts to engage employer groups in the commercial self-funded market in the discussions related to financing behavioral health treatment coverage, the MIA invited representatives of the MidAtlantic Business Group on Health (MABGH) to participate in the MIA's MHPAEA Workgroup meetings and to present at the March 22, 2021 meeting of the Finance Subcommittee. MABGH is a coalition, consisting mostly of large corporations that provide self-funded health coverage for their employees, with the overarching purpose of maximizing the return on the money member companies spend on health coverage for their employees. At the March 22 Finance Subcommittee Meeting, MABGH emphasized that systemic reform to improve access to effective behavioral health treatment would result from multi-stakeholder engagement and would involve collaboration at the national and regional levels between providers, employers, regulators, and others.

MABGH noted that enhancing coverage for tele-behavioral health services is one of the primary strategies the self-funded market is pursuing to improve access to behavioral health treatment. MABGH also attended several of the MIA's MHPAEA Workgroup meetings and expressed public support for the MIA's efforts on the Mental Health Parity reporting front, including the approach proposed in the MIA's final draft regulations and template forms.

Recommendation Sixteen: Formalize a Statewide Planning Body to address the needs of justice involved persons with behavioral health disorders

Formalize the work of the commission to ensure long term planning, implementation, and funding to address issues raised in the Sequential Intercept Model (SIM) Summit. Generally state strategies for Criminal Justice/Behavioral Health collaboration include Executive Orders, enabling legislation or Administrative Orders from the State Chief Judge. Examples can be found in the following states: Michigan, Ohio, Texas and Virginia.

A specific planning/advisory group focused on addressing individuals in the criminal justice system dealing with mental and behavioral health disorders is critical. This body should work in collaboration with the Maryland Behavioral Health and Public Safety Center of Excellence (see Recommendation 17) to maintain progress after the Commission concludes its work. The center of excellence working in collaboration with a statewide planning body can develop long-term planning, strategy, and implementation and ensure the vital work of the commission will endure past its termination.

Recommendation Seventeen: Develop a Mental Health-Criminal Justice Center of Excellence

Centers of Excellence centralize criminal justice/mental health resources, events, and initiatives to disseminate information, track diversion activity, publish outcome metrics, aid in planning, provide resources, technical assistance and training. These centers also coordinate statewide Sequential Intercept Model Mapping Workshops to summarize results and priorities that inform cross agency planning and program development.

In 2021 the General Assembly enacted, and Governor Hogan signed into law HB 1280/SB857 establishing the Maryland Behavioral Health and Public Safety Center of Excellence within the Governor's Office of Crime Prevention and Youth and Victim Services.

The center will act as a statewide clearing house for behavioral health related treatment and diversion programs develop a strategic plan to increase treatment and reduce detention of those with behavioral health disorders in the judicial system and provide technical support for localities to develop behavioral health support systems for those involved in the criminal justice system.

2022 Update: Continue to support the Behavioral Health and Public Safety Center of Excellence during the transition process and continue to monitor the implementation of, Senate Bill 857 and House Bill 1280: Specifically:

- Provide feedback on the University of Maryland's multi-year strategic plan to implement the recommendations of the Annual State Sequential Intercept Model Summit. Ensure goals are SMART and resources are clear.
- Ensure communication and collaboration between the Center of Excellence Advisory Board and the Commission on Mental and Behavioral Health, including potentially a common member.
- Identify and secure federal funding to support goals of the center including: behavioral health crisis grants, training for 9-1-1 Operators, peer support services, behavioral health screenings, scholarships for students at HBCUs,statewide resources for counties to access and behavioral health initiatives in rural communities
- Advocate for the technical assistance to local jurisdictions to create two-year behavioral health and public safety plans

Recommendation Eighteen: Broaden and Formalize County-level Criminal Justice/Behavioral Health Planning Committees

Early review of the discussion from the SIM intercept groups suggests that county level criminal justice/behavioral health planning is uneven across the state. Several counties are involved in Stepping Up Initiatives, while others may have Police Crisis Intervention Team Advisory Boards, or Treatment Court Advisory Boards or have cross county committees as the result of local Sequential Intercept Mapping. The State should help strengthen cross-county partnerships and learning. In addition, the state should work with the SAMHSA to deliver a “Train-the-Trainers” course for SIM mapping. The establishment of the Maryland Behavioral Health and Public Safety Center of Excellence will facilitate formalizing and standardizing county-level criminal justice and behavioral health planning.

Recommendation Nineteen: Standardize and formalize reporting on Mental Health Parity Non-Quantitative Treatment Limitations

In accordance with Senate Bill 334, Chapter 619, Acts of 2020, the MIA will be finalizing regulations and template reporting forms before the end of 2021 that will ensure uniform definitions and methodology for the Mental Health Parity reports commercial carriers are required to file with the MIA by March 1, 2022. These reports are designed to assess whether carriers are applying non-quantitative treatment limitations more restrictively to behavioral health benefits than to medical/surgical benefits. The MIA recommends focusing its analysis and review of the reports on the non-quantitative treatment limitations that affect access to behavioral health care services most impactfully, including provider credentialing, contracting, and provider reimbursement rates.

Recommendation Twenty: Improve access for Maryland's youth and families to vital information

Clear, concise, and consistent information on how to access treatment and support for mental health and substance use disorders is vital. We can provide this on websites managed by the State and expand community outreach and education by: (1) Use of clear, concise language and infographics; (2) Ensuring accessibility of electronically-based information that conforms with State and federal law; and (3) Provide short, community-focused videos regarding resources and services for youth and families living with mental and behavioral health issues.

2022 Update: Please see the 2022 update for recommendation eight.

2022 Recommendations

Recommendation Twenty-One: Launch a campaign to explain the negative effects of Marijuana

With the legalization of the personal use of marijuana, it is incumbent on the state to explain to the public that marijuana usage is not completely safe. There is a perception that marijuana usage is safe and natural. That is not true.

While the federal government has failed to adequately research the positive and negative effects of the regular usage of marijuana, data are available that point out the negative effects of regular marijuana use on individuals, particularly on young smokers. A 2020 report from the National Institute on Drug Abuse found exposure to marijuana during childhood impacts later cognitive ability, including memory, attention, motivation, and learning. Studies have found similar issues for both adolescents and college age students.

In addition, studies have linked frequent marijuana use in young people to increased rates of schizophrenia, depression, and anxiety. One Lancet article reported that smoking "high-potency marijuana every day" increases chances of developing psychosis by nearly five times.

Lastly, the health community has long warned of the adverse health effects of tobacco and recently vaping. However, there is little, or no caution associated with inhaling smoke from a marijuana plant into a person's lungs. A recent study published in the journal Radiology, found that marijuana smokers, with and without tobacco, had a higher rate of emphysema, airway inflammation and other conditions than those who refrained.

Recommendation Twenty-Two: The current Danger Standard for Involuntary Commitment creates inconsistent application and is inadequate to the needs of families and the public in general.

Under current law, a person can be involuntarily committed for "inpatient care or treatment" if, among other requirements, the individual "presents a danger to the life or safety of the individual or of others" (commonly known as the "Danger Standard"). The Danger Standard is too vague to address the challenges that families and the public face in getting help for a person with severe mental health issues. Courts, law enforcement, and medical personnel often interpret the standard as the presence of an immediate danger to life or safety. This standard does not look at the individual's history or whether they possess a grave disability.

At the very least the definition of "danger" within the Danger Standard should be further defined to include:

- That the danger to self or others need not be imminent, but recent and relevant to the danger that the individual may present;
- That the individual, through threats or actions, has placed others in reasonable fear of physical harm;
- Where the individual has threatened or attempted suicide, or behaved in a manner to indicate an intent to harm themselves;
- Where the individual has behaved in a manner that indicates he or she is unable, without supervision and assistance to meet his or her needs, including nourishment, medical care, shelter or self-protection or safety as to create a substantial risk of bodily harm, serious illness, or death; and
- That the patient's mental health history is relevant to any decisions on the patient's treatment and care.

Recommendation Twenty-Three: Address workforce shortages in the correctional system for mental and behavioral services

- Nationally, mandatory overtime, work overload, competition from other fields, stigma, lack of opportunity for professional growth, non-competitive compensation and benefits all contribute to the growing issues of staff shortage and high turnover within this field. As the new administration transitions in, we recommend that state employees in this field (both mental and behavioral health) are specifically studied as a subset of the state workforce adequacy. Maryland should consider salary benchmarks, loan forgiveness, and licensure requirements to create a package to reduce vacancies and improve employee retention rates.

Conclusion

This 2022 report represents the work of the Commission over the final calendar year of the Hogan-Rutherford administration. We have seen progress on many fronts with several of the Commission's recommendations put into action. Lt. Governor Rutherford met with the incoming administration and strongly encouraged the Moore-Miller administration to build upon the progress of this Commission.